EXHIBIT

D

NJ DOBI hn9176792 01 PP

Carrier Name: Health Net

Carrier Address: 90 Matawan Rd. 5th Floor Matawan, NJ 07747

YOU MUST COMPLETE A SEPARATE APPLICATION FOR EACH CLAIM APPEALED

A. Provider Information

1. Provider Name: Marc A. Cohn, M.D. | 2. TIN: 22-1947019

3. Provider Group (if applicable):

4. Contact Name: Jamie | 5. Title: Billing

6. Contact Address: P.O. Box 297 Cedar Knolls, NJ 07927

7. Phone: 973-538-4444 EXT 212 | 8. Fax: 973-538-0420 | 9. Email:

B. Patient Information

1. Patient Name: [redacted] | 2. Ins. ID: [redacted]

Medical Record: | 3. Have you attached a copy of (check the appropriate response):

a. the assignment of benefits? ☐ Yes ☐ No ☐ NA

b. the *Consent to Representation in Appeals of Utilization Management Determinations and Authorization to Release of Medical Records for UM Appeal and Arbitration of Claims*? (Not required for this appeal, but **required if** the matter goes to arbitration.) ☐ Yes ☐ No

C. Claim Information

1. Claim # (if known): | 2. Date of Service:

3. Claim filing method (check only one):
a. ☐ electronic (**submit** a copy of the electronic acceptance report from Our clearinghouse or Us)
b. ☐ facsimile (**submit** a copy of the fax transmittal)
c. ☐ mail or courier service (**submit** a copy of the delivery confirmation evidence)

4. Read the following and check the condition(s) that describe this appeal:
a. ☐ Action has not been taken on this claim
b. ☒ Dispute of a denied claim → provide **date of denial**: 05/29/10
c. ☐ Claim was paid but not in a timely manner (provide more information):
☐ Yes ☐ No Additional information was requested? If yes, date: / /
☐ Yes ☐ No Additional information provided? If yes, date: / /
☐ Yes ☐ No Interest paid correctly?
d. ☐ Claim was paid, but the amount is in dispute (not including interest)
e. ☐ Dispute of carrier's allegations of overpayment or amount of overpayment
f. ☐ Dispute of carrier's offset amount against this claim

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CDC

In an attachment, explain why you dispute handling of the claim. Be specific about billing codes. Also, submit (copies only):

- ☆ The relevant HCFA 1500(s) or UB92(s)
- ☆ The relevant Explanation(s) of Benefits or Remittance Advice
- ☆ A statement specifying the line items that you are appealing
- ☆ Information We previously requested that you have not yet submitted, if available
- ☆ Itemization of the contract provisions you believe We are not complying with, if any
- ☆ Pertinent correspondence between you and Us on this matter
- ☆ A description of pertinent communications between you and Us on this matter that were not in writing
- ☆ Relevant sections of the National Correct Coding Initiative (CCI) or other coding support you relied upon IF the dispute concerns the disposition of billing codes
- ☆ Other documents you may believe support your position in this dispute

Signature: [signature]

Date: 06/03/10

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THE SPINE INSTITUTE, P.A.

4 Campus Drive, 1S • Parsippany, New Jersey 07054 • (973) 538-4444 • Fax (973) 538-0420 or 0425

MARC A COHEN, M.D., FAAOS, FACS
Diplomate American Board of Spinal Surgery
Diplomate American Board of Orthopaedic Surgery
Fellow – American College of Spinal Surgery

June 3, 2010

Health Net
90 Matawan Rd. 5th Floor
Matawan, NJ 07747

Regarding: [redacted]
ID#[redacted]
Date of Service: 02/02/10

I recently received your denial for D.O.S. February 2, 2010, stating "claim has been denied because provider is not within the member's assigned network." I feel this is incorrect because on January 20, 2010 my office spoke with Sabine from health net and were informed no authorization was required.

I may ask that you reconsider my bill for payment as this procedure was medically necessary and the patient does have out of network benefits.

This letter will act as my letter of appeal. Any questions please call 973-538-4444 Ext 212.

Sincerely,

Marc A. Cohen, M.D.